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BACKGROUND

Unintended pregnancy remains a significant public health challenge in the 21st century. Up to 50% of all pregnancies are thought to be unintended at conception. Due to the rapid return of fertility and sexual activity, the postpartum period is high-risk for unintended pregnancy, and the need for effective contraception at this time has long been underestimated.

A short interpregnancy interval (defined as less than 12 months between childbirth and subsequent conception) is an independent risk factor for preterm birth, fetal growth restriction and stillbirth.[1] Furthermore, many unintended pregnancies at this time will end in abortion, with an estimated one in thirteen women attending an abortion clinic in the UK within a year of giving birth.[2]

One of the key strategies to reduce unintended pregnancy and abortion at this time is already within our clinical armoury: long-acting reversible contraception (LARC). LARC is safe for use by most women, including during the immediate postpartum period and while breastfeeding.[3] LARC methods are also the most effective at preventing unintended pregnancy and are highly cost effective. Initiating LARC immediately postpartum has also been shown to significantly reduce the risk of a short interpregnancy interval. But for a new mother, LARC can be the most challenging method to access.

After leaving the delivery suite, contraception is not usually a priority for women as looking after the newborn and recovering from childbirth predominate. But delaying this discussion until a postnatal check 6 weeks later with a general practitioner (GP) is also less than ideal. Increasing GP workloads and limited consultation times means that a full discussion and initiation of contraception can be challenging, especially for LARC methods which often require additional appointments to start.[4] Given that at least 50% of couples will have resumed sexual activity by 6 weeks' postpartum, these barriers may further delay or discourage access to highly effective contraception at a time when there is a risk of unintended pregnancy.

Increasing emphasis is therefore being placed on maternity services, with the support of their community colleagues, to provide contraception immediately postpartum. However, developing the clinical infrastructure, training and resources required to achieve this can be complex. Despite these difficulties, there are many encouraging examples of this in current UK practice, and here I will consider the experience of NHS Lothian (Edinburgh. Scotland) to highlight some of these.

ANTENATAL CONTRACEPTIVE COUNSELLING

A busy postnatal ward may not be an ideal setting in which to introduce contraceptive discussion for the first time and is not the preference of women or staff.[5] In contrast, the antenatal period is a time when women are often in contact with many different healthcare providers, offering multiple opportunities to discuss contraception, and adequate time for women to consider their options more fully.

A pilot project in Lothian in 2014 showed that it was feasible to implement antenatal counselling by community midwives, and that this was acceptable to both women and staff.[6] Following this, all pregnant women in the region are now offered contraceptive counselling at around the 20-week antenatal visit as part of the routine pregnancy pathway. Advance decision-making regarding postnatal contraception can help to facilitate more timely provision after childbirth.

Most of the current UK public health strategies now recommend the integration of contraceptive discussion into routine antenatal care. However, to ensure women's postpartum contraceptive choices can supported, this needs to be coupled with access to a range of methods.

ENHANCED PROVISION OF POSTPARTUM METHODS

The Faculty of Sexual & Reproductive Healthcare (FSRH) *Contraception After Pregnancy* guideline supports the initiation of most methods of contraception immediately postpartum (with the exception of combined hormonal methods).[3] While oral contraceptives and injectables can be relatively easily stocked on a postnatal ward, the challenge in offering LARC is that these methods require trained providers to fit them. Furthermore, these providers need to be present in sufficient number to achieve 'round the clock' provision within the unique clinical context of labour and delivery.

This can be accomplished by training both midwives and obstetric doctors to insert implants in the maternity setting, which has been successful in Lothian through the development of a tailored training package. Notably, the FSRH has recently introduced an insertion-only Letter of Competence to meet the specific training needs of these providers. Locally there have also been successful programmes of postpartum implant insertion at home by community midwives for particularly vulnerable groups of women,[7] further extending access to postpartum LARC.

However, women's contraceptive choices immediately postpartum have generally failed to include intrauterine contraception (IUC). This is usually delayed until 4 or 6 weeks' postpartum (interval insertion), despite current FSRH recommendations supporting insertion within 48 hours.[3] It also known that only around 50% of women attend for interval postpartum insertion, even when these appointments are made at the time of delivery.[2] Therefore, the logical approach is to provide postpartum intrauterine contraception (PPIUC) insertion at the time of childbirth.

IMMEDIATE POSTPARTUM INTRAUTERINE CONTRACEPTION

The concept of PPIUC is not new: it has been offered in numerous low- and middle-income settings for many years and there is now a wealth of evidence to support its safety.[8] The device can be inserted via the uterine incision at caesarean section (either manually or using an instrument) or at vaginal birth using specialised (Kelly) forceps to achieve adequate fundal placement within the enlarged postpartum uterus.

Intra-caesarean IUC insertion was introduced to the Lothian region in 2015, and around one in seven women having an elective caesarean section now choose this option. Previously published outcomes demonstrated a low rate of complications with this procedure, and almost three out of four women have continued IUC use at 12 months' postpartum.[9] Notably, there is a higher likelihood of non-visible threads at 6 weeks' postpartum, necessitating the need for formal follow-up examination (and access to ultrasound if required).

Intra-caesarean provision is a positive step towards extending the availability of LARC at the time of childbirth. However, as the majority of women will experience a vaginal birth, they should not be disadvantaged in their ability to access PPIUC. The vaginal PPIUC insertion technique is one with which many UK clinicians are unfamiliar, and this can lead to uncertainty and reluctance to provide it. There is also limited evidence about how to implement this complex health intervention in practical terms.

In an attempt to further knowledge in this area and investigate vaginal PPIUC provision in a 'real world' context, we established a health service evaluation study in Lothian in 2017. Obstetric doctors and labour ward midwives were trained to insert vaginal PPIUC, and eligible women could choose to access this service following antenatal discussion with their community midwife. Over 400 women to date have received PPIUC insertion at vaginal birth, with our published findings expected early next year.

One of the often-cited limitations of vaginal PPIUC provision is the higher rate of device expulsion. The actual reported rate varies considerably between studies, from as low as 4% to over 30%,[8] with lower rates observed among highly experienced inserters.

Within the catalogue of postpartum LARC, immediate IUC insertion remains the most difficult to access in the UK as PPIUC services are not widely available. Although there is a growing interest among clinicians to provide this, routine implementation is not without its challenges and there is an important need for 'early adopters' to share their experience and knowledge in order to progress this further.[10]

SUPPORTING THE 'LIFE COURSE' APPROACH TO WOMEN'S HEALTH

The antenatal period presents a unique transitional time with the opportunity to address women's future health and reproductive needs, alongside those directly related to the current pregnancy. Postpartum contraception has an important role in reducing the risk of an unintended pregnancy in the months after childbirth, as well as supporting women and couples to optimally plan and space their future pregnancies.

As healthcare professionals we can encourage this by providing opportunities to discuss future fertility intentions and by facilitating easier access to a range of contraceptive options and the most effective LARC methods, including in non-traditional settings such as the labour ward. By doing so we can remove some of the barriers that currently exist for women accessing

contraception at this time, and achieve truly holistic care of women during pregnancy, childbirth and beyond.

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